(6)

No. 97-1489

In The

Supreme Court of the United States

October Term, 1998

YOUR HOME VISITING NURSE SERVICES, INC.,

Petitioner,

v.

SECRETARY OF HHS,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Sixth Circuit

PETITIONER'S REPLY BRIEF

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24 pp

TABLE OF CONTENTS

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES – Continued

PETITIONER'S REPLY TO RESPONDENT'S BRIEF ON THE MERITS

This brief is submitted in accordance with United States Supreme Court Rule 24.4 which allows petitioner to reply and does not require a summary of the argument if the brief is appropriately divided by topical headings.

I. Defining the phrase "final determination" in 42 U.S.C. § 1395oo.

The respondent asserts that § 1395oo(a) is most naturally read to confer a right to review of a Notice of Amount of Program Reimbursement (NPR) but not an intermediary's "mere" refusal to revisit that determination, and seeks support for this conclusion in § 1395oo(a) which confers a right to a "hearing" by the Board, including the right to present evidence and cross-examine witnesses. Resp't Br. 15. Petitioner disagrees with this reading since it limits the plain language of the statute. *See* Pet'r Br. 7-10. The language simply refers to a final determination, not to the Notice of Amount of Program Reimbursement as the final determination. In *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988) the Court refused to accept the Secretary's "strained interpretation" of the word "dissatisfied" as it appears in § 1395oo(a). *Id.* at 404. Similarly, the Court should refuse to accept the Secretary's restrictive reading of the phrase "final determination" and instead accept the plain meaning of the statute on this matter which would encompass the NPR as well as a final determination not to reopen a Medicare cost report as the decision which activates the right to review contemplated by § 1395oo(a). Petitioner qualified for a hearing under the statute:

a. The amount in controversy is greater than $10,000;

b. The petitioner filed its request for a hearing within 180 days of the intermediary's refusal to reopen;

c. The petitioner is dissatisfied with a final determination of the intermediary as to the amount of total reimbursement due the provider.

Here petitioner sought relief by resort to the administrative appeal process contemplated by Congress when it enacted § 1395oo(a). Social Security Amendments of 1972, H.R. Rep. No. 92-231 (1972), *reprinted in* 1972 U.S.C.C.A.N. 4989,5094. The Court in *Bethesda Hospital Association* recognized that petitioners who resort to the statutorily prescribed appeal procedure "stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement." *Id.* at 404-405. Petitioner respects the process outlined in the statute and seeks review within that system.

Section 1395oo is a broad jurisdictional statute. Respondent acknowledges that pursuant to the statute, it may "amplify" the Board's jurisdiction (Resp. Br. at 19 n.7). However, it lacks the authority to narrow the statutorily mandated jurisdiction of the Board to preclude it from reviewing a decision that meets the enumerated criteria under § 1395oo(a). The final determination is reviewable under the statute and therefore within Board jurisdiction for review. It is disingenuous for respondent to argue that, on the one hand, a denial of a request for reopening is not a "final determination . . . as to the amount of total reimbursement due the provider", while on the other hand, acknowledging that "reopening often results in additional program reimbursement to the provider." (Resp. Br. at 32) Petitioner maintains either action is a determination as to the amount of *total* program reimbursement due the provider. As such, the administrative review process is applicable.

Respondent characterizes a refusal to reopen as a decision not to alter the provider's total program reimbursement which the Secretary reasonably determined did not need to be reviewed.

Resp't Br. 32. The statute does not require an alteration in reimbursement as the mechanism which sets the

review process in motion. It simply states that a provider dissatisfied with a final determination as to the amount of total reimbursement due the provider for the period covered by such report may obtain a hearing. 42 U.S.C. § 1395oo(a). Petitioner met the statutory requirement.

The review process is crucial to providers who seek additional reimbursement. The intermediary's refusal to reopen a cost report cannot be dismissed as a "mere" refusal to revisit the previous determination. Indeed, the Secretary's contention that reopening regulations were promulgated to meet her "practical need to reopen . . . when there is reason to believe that intermediaries made payments that are not reimbursable under the Act," not only evidences her one-sided view of the reopening process, but is an acknowledgement that intermediaries do make mistakes. (Resp. Br. at 34). *See also Oregon v. Bowen*, 854 F.2d 346, 350 (9th Cir. 1988). With only 37 intermediaries to review the cost reports of 38,000 providers, it is conceivable, if not probable, that an intermediary may err in denying reopening to a provider that presents new and material evidence or finds a clear and obvious error. PRM § 2931.2. Without a review process, there is no remedy for the wrong.

II. Refusal to Reopen is not always a refusal to revisit a previous determination.

Petitioner also notes that characterizing the refusal to reopen a cost report as a refusal to revisit the previous determination does not properly describe circumstances where new and material evidence is the basis for the request. If new and material evidence is at issue, then the intermediary would be reviewing it for the *first* time – a circumstance that cannot be considered a refusal to revisit a previous determination.

Respondent asserts petitioner did not claim entitlement to the sort of evidentiary hearing specified by

§ 1395oo(c). Resp't Br. 15. In fact, petitioner would certainly need an evidentiary hearing of that nature to present facts concerning the refusal to reopen in order to demonstrate an abuse of discretion. The Provider Reimbursement Review Board (PRRB) offers this type of hearing under § 1395oo(c) for providers located in the Ninth Circuit and has often found abuse of discretion in denials of reopening requests. *See* Pet'r Br. 31. Indeed, this Court envisioned some type of judicial review process available to determine whether such refusal was arbitrary, capricious, or an abuse of discretion. *Interstate Commerce Comm'n v. Brotherhood of Locomotive Eng'rs*, 482 U.S. 270, 271 (1987). Without the benefit of a hearing outlined by § 1395oo(c), a petitioner might have difficulty establishing its case of abuse of discretion. The only evidence in this case concerning the refusal to reopen is a two-page letter which offers conclusions rather than explanations. *See* J.A. 28-29. Petitioner again asserts that when an action is taken by the Secretary, that action must be taken in such a manner as to enable a reviewing court to determine whether or not the Secretary's discretion was exercised properly. *Dunlop v. Bachowski*, 421 U.S. 560, 573 (quoting *DeVito v. Shultz*, 300 F. Supp. 381, 383 (D.D.C. 1969)). Without the evidentiary hearing specified in § 1395oo(c), the reviewing court or the Board would have little evidence available for a decision. Since the review system for Medicare reimbursement issues contains an administrative process whereby a record will be developed which can later be judicially reviewed, it makes sense for a case involving a refusal to reopen to proceed through the PRRB process before judicial review, including the evidentiary hearing noted at § 1395oo(c).

III. The reopening process is not purely a creature of the Secretary's regulations.

Petitioner continues to rely upon the reasoning of the Ninth Circuit in the *Oregon v. Bowen* case which preserves the presumption of judicial review and which found

support for Board jurisdiction in the plain meaning of § 1395oo, the congressional intent and in § 1395x(v)(1)(A)(ii), the statutory provision which requires retroactive corrective adjustments to assure that reimbursment is neither inadequate nor excessive. Later decisions in the Ninth Circuit have questioned reliance upon § 1395x(v)(1)(A)(ii) as statutory authority for the reopening process due to the Court's ruling in *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402 (1993). Resp. Br. 21, footnote 8. Petitioner believes the Ninth Circuit's concern in this regard is unfounded. The question presented in *Good Samaritan* was whether the Secretary must afford the six petitioning hospitals an opportunity to establish that they are entitled to reimbursement for costs in *excess of such limits*. The Court held that clause (ii) did not require such an opportunity. Petitioner agrees with that assessment but does not believe it stands for the proposition that § 1395x(v)(1)(A)(ii) cannot be considered the statutory basis for the reopening process. The Court's conclusion was based upon its refusal to accept the assertion that "reasonable" cost could be defined outside of the Medicare statute, which would allow for *more* Medicare reimbursement than the *methods* employed by the Secretary to define reasonable reimbursement. Petitioners in *Good Samaritan* were asking that *all* their costs be considered reasonable, even those which exceeded the cost limit established by the Secretary.

The Secretary's "book-balancing" argument was plausible in the circumstances of *Good Samaritan* where the competing interpretations were driven by the question of whether or not retroactive adjustment would be made to give providers *all* of their costs, even if their costs *exceeded* the limits. A different circumstance is presented in this case where the petitioner asserts that clause (ii) is statutory authority for the reopening process where retroactive corrective adjustment must be made to properly pay allowable reasonable costs *within* the applicable cost limits.

(a) The statute requires the reopening process.

Petitioner previously stated its position that the mandatory language noted in § 1395x(v)(1)(A)(ii) requires retroactive corrective adjustments to assure that reasonable costs for Medicare services are paid. Pet'r Br. 13-14. This position is supported by the discussion on pages 413-414 of the *Good Samaritan* decision where the Court notes the agency viewed clause (ii) as a directive for retroactive adjustment of payments for allowable costs, as determined by the established methods. *See Good Samaritan*, 508 U.S. at 413-414. After the 1972 cost limit amendments were added "the agency appears to have ascribed the same role to clause (ii), namely, to retroactively correct the differences between interim payments and *reasonable* costs – only as a result of the amendments the adjustments would now be based on the *new* definition of reasonable costs which includes the cost limits." *Good Samaritan*, 508 U.S. at 416. Since petitioner sought only to obtain its reasonable costs under the definitions developed by the Secretary, the Court's holding in *Good Samaritan* supports reliance upon clause (ii) as the statutory mandate for the reopening regulation. Clause (ii) requires the Secretary to promulgate regulations which allow a provider to request reopening for corrections to reasonable reimbursement which are authorized by the Secretary's own regulations concerning that reimbursement.

While Petitioner accepts the majority decision of *Good Samaritan*, the dissenting opinion also addressees points about the statute which should be considered in the present case. The dissenting opinion recognized the *mandatory* nature of the fourth sentence of § 1395x(v)(1)(A) and stated that clause (ii) requires the regulations to provide for suitable corrective adjustments where the method of determining costs produces a reimbursement that "proves to be either inadequate or excessive." *Good Samaritan*, 508 U.S. at 426.

Although petitioner agrees with the dissenting opinion where it finds that the Secretary is required to promulgate such regulations, it respectfully submits that the majority opinion of the Court was correct in not allowing payment in excess of the methods the Secretary established. Nevertheless, petitioner believes the dissenting opinion correctly recognized that clause (ii) should be considered statutory authority which *unambiguously* requires the promulgation of regulations allowing providers (and the Secretary) to seek adjustments if reasonable costs were not paid, or if excessive costs were paid. Indeed, this is the essence of petitioner's reliance upon clause (ii) as the statutory basis of the right to seek retroactive corrective adjustments through the reopening process when the Secretary failed to pay reasonable cost of owners compensation as defined by the Secretary's own regulations for owners compensation. *See* Pet'r Br. 13-15.

In further support for petitioners position that § 1395x(v)(1)(A)(ii) is statutory authority for the reopening regulations is the citation to that statutory section as the source of authority for the regulations contained at Subpart R – Provider Reimbursement Determinations and Appeals. (42 C.F.R. § 405.1801 et seq. citing Soc. Sec. Act §§ 205, 1102, 1814(b), 1815(a), 1833, ***1861(v) (which is 42 U.S.C. § 1395x(v))***, and 1871, 1872, 1878 and 1886.) The only regulations which concern retroactive corrective audit adjustments (the subject matter of clause (ii)) are the regulations which require reopening. Since the Secretary actually cited the statutory authority for her reopening regulation, it cannot be said that the reopening process is purely a creature of regulation. It is required by the Act itself and cannot be ignored.

The emphasis on statutory authority is being made to answer one of the questions at hand. Petitioner asserts that the *statute requires* the retroactive adjustments it sought. A review process is necessary to prevent the intermediary from ignoring the requirement. When there

is no review process, the Secretary is free to disregard the law without consequence.

(b) Book balancing beyond year end.

The respondent asserts that clause (ii) is statutory authority only for year end book-balancing, i.e., reconciliation of the actual "reasonable" costs under the regulations with the interim payments. The evidence in this case and many others demonstrates that the Secretary herself treats the reopening process as part of the book-balancing required by the statute. In *Good Samaritan* the Secretary asserts that the interim payments are based on the methods chosen by the Secretary to determine reasonable costs, but they are only anticipatory estimates . . . *made before all relevant data are available. Good Samaritan*, 508 U.S. at 411 (emphasis added). Respondent concedes that when data becomes available which indicates that a provider was *overpaid*, the intermediary reopens the cost report to recover the excess amount of reimbursement. This happened to this petitioner for the same cost report at issue herein. The 1989 Sneedville cost report was reopened because petitioner discovered and reported to the intermediary that a nurse employee did not have a valid license. *See* Pet'r Br. 14. The Secretary reopened the cost report to recover the money paid to the nurse because Medicare requires that nurses have valid licenses as a condition of payment. Nevertheless, when data became available to petitioner which showed its owners had been underpaid, the intermediary refused to reopen the same cost report. Petitioner asserts these two events are both properly characterized as book-balancing to reconcile actual costs to allowable costs.

The limited definition of the book-balancing as a year end function only for comparing the interim payments to the final amount allowable on the NPR at year end does not address circumstances in which new data about reasonable costs becomes available after the NPR is issued. Petitioner urges the Court to adopt its view of clause (ii)

as statutory authority which requires the Secretary to promulgate regulations to address retroactive corrective adjustments at year end or later. This approach would retain the book-balancing concept of clause (ii) without limiting its application to a year end timetable. In *Good Samaritan* neither the Court nor the agency limited the correction to a specific time frame whereas the Respondent now asserts that clause (ii) was construed by this Court to narrowly refer only to year end book-balancing of monthly estimated payments as compared to the final amounts determined by the intermediary in the NPR. Resp't Br. 20-21. The statutory language does not support this very narrow interpretation nor did the Court endorse that precise definition of book-balancing. Petitioner reads clause (ii) as statutory authority for the reopening process which should occur when retroactive corrective adjustments are needed. These adjustments might be apparent at year end, but events might also occur at a later date, after year end NPR's are issued, which would also call for the retroactive adjustment to cost. Defining the time frame for the book-balancing as being cut off at the year end (NPR stage) for the Secretary (as well as the provider) would severely restrict the intermediary's ability to make corrective adjustment when mistakes are discovered after the NPR is issued. As it stands now, only the provider is restricted to the year end timetable since the Secretary can and will reopen beyond year end to recover reimbursement. Instead of accepting this inequity, petitioner asks this Court to rule that the three year time period within which cost report requests for reopening must be made, should be read in tandem with the time period for book-balancing under clause (ii). This would allow the intermediary three years to correct errors and to make retroactive corrective adjustments. This is the more plausible reading of the statute.

Additional support for the three year period being the appropriate time frame within which to make book-balancing corrective retroactive adjustments can be found in the brief submitted by the Secretary of Health and

Human Services in *Regions Hosp. v. Shalala*, 118 S.Ct. 909 (1998), where she argued that the reaudit rule for GME was appropriate because it does not permit the Secretary to reopen administratively settled cost reports to recoup overpayment to providers during those "closed periods." Brief for the Respondent at *15, *St. Paul-Ramsey Medical Center, Inc. v. Shalala*, 1997 WL 567286 (No. 96-1375) (reported as *Regions Hosp. v. Shalala*, 118 S.Ct. 909 (1998)); (*See id.* at 12-13, n.5 where the Secretary describes the time frame for reopening for purposes of altering the total amount of reimbursement as expired as of three years and one day after the initial NPR, in essence defining a closed period as one which is beyond the three year period). The brief went on to state that although the 1984 cost report had paid excessive reimbursement for GME costs, no recoupment action was taken against it because the "cost report had been finally determined." *Id.* at 13. This brief demonstrates that in *Regions Hosp.*, the Secretary placed emphasis upon the three year time period for reopening. The cost report is described as closed, "finally" determined and no longer subject to administrative review or reopening if the three-year time period had elapsed.

Now the Secretary wants to limit the time period for change to 180 days, where she previously argued the three-year time frame as the applicable statute of limitations for change. The Secretary should not have the advantage in both circumstances. The Secretary would limit the provider to the 180-day statute of limitations for requesting changes by way of appeal of the NPR and yet allow herself three years to go back to the providers and recover funds.

Respondent defends this approach (Br. 33) by citing the Secretary's responsibility to the public fisc, and yet Congress saw fit to place the providers and the Secretary on an even playing field when it drafted the language of clause (ii) which states that the Secretary ***shall*** promulgate regulations which provide for the making of suitable retroactive corrective adjustments where the aggregate

reimbursement produced by the methods of determining costs proves to be ***either*** inadequate or excessive. The statute contains a mandate for the Secretary to promulgate regulations for this process. Therefore, the Secretary is incorrect in her assertion that she may choose to eliminate the reopening process altogether. Resp't Br. 36, n.14.

IV. The Interest in Finality

Respondent argues that it would be inconsistent with concepts of administrative finality to require the Secretary to confer a right of review by the Board with respect to all refusals by intermediaries to reopen reimbursement determinations. Petitioner asserts that it is the Secretary's position which defeats the goal of finality. If the Court adopts the Secretary's position as correct, the logical response from providers would be to file more PRRB appeals in order to preserve their right to retroactive corrective adjustments in the event of discovery of new and material evidence or a clear and obvious error after the 180th day. In other words, the 180 days for appeal to the Board would be the only guarantee of an appellate process available for providers under the Secretary's reading of the Act. Any wrongful conduct discovered on the 181st day could be insulated from judicial review. In this sense, the Secretary's interpretation of the Act would actually defeat finality because it would encourage providers to file more PRRB appeals within this limited 180 day period as a precautionary measure. This interpretation of the Act creates the potential of the Board appeal, filed within 180 days of the NPR, being the providers' one and only chance for obtaining corrective retroactive adjustments. As the Secretary's own Ruling No. 97-2 reveals, she will not reopen settled cost reports to make corrections if providers do not have pending appeals, even when courts have determined her regulations for payment unlawful. *See* Amici Br. App. 1-3. This approach leaves the provider that did not file an appeal underpaid even if the cost report is still subject to reopening within

the three-year period if there is a refusal to reopen the cost report.

Under petitioner's view, it would be more appropriate to allow providers a meaningful right to request reopening within the three-year time period if the appropriate circumstances justify such a request. Petitioner's view of the statute, which allows review of the refusal of the request, would not impair finality since the requests for reopening would occur only when the providers discovered new and material evidence or a clear and obvious error and would remain limited within the three year time period for revision. Contrast the Secretary's system which would actually encourage increased litigation through numerous appeals. This would leave fewer cost reports finalized. The Secretary's approach defeats the congressional goal of finality. This Court stated that "only when a petition to reopen and reconsider an agency order alleges new evidence or changed circumstances is the agency's refusal to reopen subject to judicial review, and then, only as to whether such refusal was arbitrary, capricious or an abuse of discretion." *Interstate Commerce Comm'n*, 482 U.S. at 271. Often facts and circumstances which warrant review come to light after the initial 180 day period for appeal of an NPR expires. A review of the reopening process will assure that providers receive proper consideration when these situations occur.

V. The reopening regulations do permit unchecked and arbitrary action by intermediaries

The respondent asserts that the Secretary has set forth detailed criteria to guide an intermediary's exercise of discretion in considering a reopening request. Based upon the existence of this criteria, the respondent believes the reopening regulations do not permit unchecked or arbitrary action. Resp't Br. 27. The fact that criteria are set forth does not guarantee that the intermediaries will abide by it. In this case, no government official has reviewed the intermediary decision to assure

it is consistent with the criteria noted by respondent. There is no evidence in the record that anyone, other than the individual who signed the letter denying the request for reopening, ever considered petitioner's grounds for making the request. There was no substantive explanation concerning the refusal to reopen. There was no description of the process which was used to make the decision to deny the request. As Amici pointed out, the individual employee of the insurance company (intermediary) could have flipped a coin to make the decision.

There is in fact, evidence in this case that the intermediary knew the determination was incorrect but still refused to reopen and make the appropriate adjustments. Petitioner met the criteria for a reopening when it submitted new and material evidence concerning the discovery of the intermediary's failure to use the salary survey (developed by the previous intermediary) to determine the petitioner's owners compensation. It demonstrated a clear and obvious error had been made when petitioner's owners were paid less than their peers. Payment was therefore not in accordance with the law. The record shows the intermediary steadfastly refused to settle the issue in the one and only cost reporting period (1989) which was not pending on appeal to the Board. The respondent tells this Court there are mechanisms to protect the provider from an abuse of discretion and yet in this very case we have documents which demonstrate the refusal to reopen cost reports for 1989 to correct the same error which was corrected in six other cost reporting periods. (The 1988 cost reports had no adjustments to owners' compensation, nor did the later closed reports for 1995 and 1996).

Petitioner invites this Court's attention to evidence of an abuse of discretion in the form of the administrative resolution (settlement) of all petitioner's pending PRRB cases on the subject of owners' compensation. On April 3, 1997, petitioner filed a Motion to Request Addition of Documents as an Exhibit in the case. The Sixth Circuit referenced this material in the footnote 1, page 4 of its

decision where the court described the document as two letters purporting to resolve the outstanding cases between the intermediary and petitioner through an administrative resolution. *See* Pet. App. The Sixth Circuit refused to address the documents because they were not considered by the District Court. Petitioner could not have offered the documents for consideration at the District Court because the administrative resolution did not occur until October 4, 1996, almost seven months after the District Court ruling on March 22, 1996. The Sixth Circuit said consideration of the documents would not have altered their ruling and the court would not accept the documents noting that they did not address the 1989 year. (The 1989 year was not addressed because the intermediary settled every year *except* 1989.)

This evidence was offered to demonstrate abuse of discretion when the intermediary refused to reopen the 1989 cost report. Petitioner references this evidence as rebuttal to respondent's assertion that the reopening process does not permit unchecked or arbitrary action by intermediaries. The respondent tells this Court that HCFA regularly imparts guidance to intermediary's as needed to promote consistent application of and adherence to the reopening standards set forth in the Secretary's regulations and PRM. Resp't Br. 27. Apparently, the consistent application of the reopening standard does not equate to consistent application of the owners compensation guidelines which were applied to settle six PRRB cases for this petitioner.

Respondent adds a footnote to say that HCFA does not maintain statistics but estimates that 30%-40% of providers' requests to reopen are granted. Resp't Br. 27. Petitioner does not believe the estimate is even remotely accurate, but even if it were, that still means 60%-70% of providers' requests to reopen are denied and unreviewable according to the Secretary. There is absolutely no factual basis offered for the self-serving claim that 30%-40% of providers' requests are granted. Whereas the facts of this case offer an actual example of a refusal to

reopen in the face of clear and convincing evidence that the reopening should have been granted. Simple math with inflation factors could have been used to calculate the appropriate amount of owners compensation for 1989, the one and only year the intermediary refused to correct. And yet, the intermediary continued to refuse to reopen the cost report to make the corrective retroactive adjustment, all of which demonstrates the respondent is wrong when it asserts the reopening regulations do not permit unchecked or arbitrary action by the intermediary. This is one of many cases which demonstrates arbitrary and capricious action on the part of the intermediary.

VI. Federal Court jurisdiction under 28 U.S.C. § 1331.

Petitioner maintains that federal question jurisdiction is available for cases which do not seek to shortcut the administrative review process, but simply fall outside of the administrative review process. In support of this position petitioner continues to rely upon the Court's ruling in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), where the Court focused upon the importance of judicial review of the regulation in question. Petitioner believes 42 U.S.C. § 1395oo(a) does allow a review process, but in the event the Court accepts the Secretary's view on this issue, petitioner again would assert reliance upon federal question jurisdiction to resolve this matter. Respondent's discussion of the changes in jurisdiction which occurred when the amount in controversy was extinguished for federal question jurisdiction do not address the fact that Congress made the change in order to open the door to litigation in federal court that might otherwise be denied.

> "An anomaly in Federal jurisdiction prevents an otherwise competent United States district court from hearing certain cases seeking 'non-statutory' review of Federal administrative action, absent the jurisdictional amount in controversy required by 28 U.S.C. section 1331, the general

'Federal question' provision. These cases 'arise under' the Federal Constitution or Federal statutes, and the committee believes they are appropriate matters for the exercise of Federal judicial power regardless of the monetary amount involved." Califano v. Sanders, 430 U.S. 99, at 99, footnote 7(1967), quoting the Senate Judicial Committee S. Rep. No. 94-996, p. 12 (1976) (emphasis supplied); *see* H.R. Rep. No. 94-1656, p. 13 (1976).

Although the petitioner is aware of the preclusionary language retained in 405(h) which respondent would apply to defeat federal question jurisdiction in this case, it is unreasonable to apply both the preclusionary language in conjunction with the concepts of exhaustion to prohibit all judicial review to situations where new and material evidence or a clear and obvious error arise after the 180 day period for the appeal from the initial Notice of Program Reimbursement. If the Secretary's reading of the Act requires elimination of judicial review through the prescribed administrative route, then it is reasonable for providers to resort to the judiciary via the federal question statute for jurisdiction to resolve this matter. Petitioner maintains the Court's ruling in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986) is applicable to this controversy if an appeal is not allowed under 42 U.S.C. § 1395oo. The petitioner presented two collateral challenges in this matter: the validity of the Secretary's reopening regulation 42 C.F.R. § 405.1885(c) and the intermediary's failure to abide by 42 C.F.R. § 413.102(b)(2)(i) which requires that owners compensation be such an amount as would ordinarily be paid by comparable institutions. Refusal to reopen the cost report to correct the error could also be defined or characterized as an abuse of discretion which is collateral to the underlying claim for additional owner's compensation. The failure to abide by the regulations governing owners compensation is also collateral to the underlying claim for owners compensation. When claims involve matters

outside the articulated statutory review process, jurisdiciton should be available under § 1331. The presumption of judicial review in every possible context cannot be dissolved by the Secretary's interpretation of the Act alone.

VII. Federal Court jurisdiction under 28 U.S.C. § 1361

Respondent asserts that petitioner raises "for the first time" the Secretary's nondiscretionary duty to pay reasonable costs. Resp't Br. 44. This is not true. Petitioner directs respondent's attention to the Complaint filed in District Court and to petitioner's Reply Brief to the Petition for Writ. *See* J.A. 58, ¶4; 60 ¶14; Pet'r Reply Br. 1-2. Petitioner continues to rely upon its arguments as previously submitted on this issue. The Secretary owes a clear non-discretionary duty to pay .in accordance with the criteria established by regulation 42 C.F.R. 413.102(b)(2)(i) to determine the amount of owners compensation.

VIII. Federal Court Jurisdiction under the Administrative Procedure Act

Respondent contends that this Court held in *Califano v. Sanders*, 430 U.S. 99 (1977), that Section 10 of the APA, does not vest federal courts with subject matter jurisdiction to review agency action, including decisions denying reopening requests. Resp't Br. 45. The question of the application of the APA to this controversy is being submitted with that decision in mind. However, the APA was addressed in *Good Samaritan* where the Court concluded the petitioner's challenge was in effect, in all but name, a challenge to the validity of methods and to their adequacy as gauges of reasonable cost and went on to recognize that "The Secretary has construed the statute to allow such attacks, not via clause (ii), but rather . . . by way of the arbitrary and capricious provision of the Administrative Procedure Act, 5 U.S.C. 706." *Good Samaritan*, 508 U.S. at 420. The Court noted that petitioners had invoked to APA at the Court of Appeals, where their

claim was rejected, but did not renew the APA claims in this Court. *Id.* at n. 16. This brings us to the question at hand where petitioner seeks a corrective retroactive adjustment because it was not paid in accordance with the Secretary's regulations and further alleges the refusal to reopen to make the corrective retroactive adjustment was an abuse of discretion, arbitrary and capricious. Petitioner herein did renew its claims under the APA as an alternative basis for jurisdiction and would urge this Court to reconsider its position in this regard as stated in *Califanc v. Sanders*, 430 U.S. 99 (1977).

Petitioner's case is also distinguishable from *Sanders* because that case involved a previously adjudicated claim which had already been reviewed through the administrative process. In *Sanders*, the claimant received the benefit of the administrative review as the claim passed through several steps of the appeal process. As a result, an Administrative Law Judge found the claimant ineligible for benefits and the Appeals Council sustained that decision. *Sanders* p.102. Not until seven years later did the respondent file a second claim, which was treated as a request for reopening because no new evidence or changed circumstances were alleged. *Id.* at 103. In the present case, the petitioner did not receive the benefit of any review process even though new and material evidence was offered to support the request to reopen its cost reports. Here we have the complete lack of any type of review process for the refusal to reopen the cost report even though new and material evidence discovered after the 180 day period for requesting administrative review in the first instance had elapsed.

Another distinguishing fact is the subject matter of the issue itself. *Sanders* concerned disability eligibility, a decision which is based upon an individual's medical condition. This is different from the calculation and recalculation which often occurs with Medicare reimbursement. The portions of the Medicare statute which must be construed in this case concern the right to retroactive corrective adjustments of Medicare reimbursement after

the 180-day period for appeal has elapsed. In *Sanders*, there was no retroactive corrective adjustment provision of law at issue.

Respondent asserts that this Court will not overrule precedent construing a federal statute unless intervening law has undercut the "conceptual underpinnings" of the decision. Resp't Br. 46. Although *Sanders* spoke to judicial review of a refusal to reopen, the conceptual underpinnings were developed in the context of a disability claimant's case, not the Medicare provider's cost reporting process. This Court has not yet been presented with the question of a Medicare provider's right to review when an intermediary refuses to reopen a cost report. *Stare decisis* is the policy of courts to stand by precedent and not to disturb a settled point. Petitioner asserts this is a case of first impression for the Court and while *Sanders* may provide guidance on the matter, its holding does not settle the precise issue at hand.

Whether the APA can be used as an independent grant of jurisdiction in this circumstance must be examined in light of the Court's holding in *Sanders*, as well as the Court's later decisions regarding judicial review of administrative action. In *Sanders* the Court concluded the APA did not afford an implied grant of subject matter jurisdiction permitting judicial review of agency action. The conclusion was based in part upon the 1976 Congressional action in re-defining § 1331 by deleting the monetary amount requirement. As mentioned earlier in this brief, the legislative history shows that Congress deleted the jurisdictional amount in order to open the door for cases seeking review of federal administrative action. (*Sanders* at 107 footnote 7) Since it is clear that Congress sought to fill a gap by eliminating the jurisdictional amount requirement in § 1331, it does not follow that the APA should remain unavailable if § 1331 does not fill the gap. The legislative action reveals congressional concern for judicial review. Petitioner seeks judicial review, first and foremost by resorting to the administrative appeal

process set out in 42 U.S.C. § 1395oo. But in the alternative, federal question jurisdiction should be available and if it is not, then the APA should be considered as a grant of subject matter jurisdiction for the review of the final administrative action which petitioner believes is an abuse of discretion.

In *Sanders*, this Court respectfully acquiesced to the Congressional policy choice, which the Court read as designed to forestall repetitive or belated litigation of stale eligibility claims. *Sanders* at 108. The Medicare Act shows Congress policy choice of correcting mistakes by requiring retroactive corrective adjustments. 42 U.S.C. 1395x(v)(1)(A)(ii). While petitioner believes Congress also envisioned an appeal process via § 1395oo(a), if this Court disagrees, then petitioner would request reconsideration of the APA as an independent jurisdictional grant to allow Medicare providers access to federal court for the review of violations of federal law which would otherwise remain completely insulated from judicial review.

CONCLUSION

Petitioner urges the Court to adopt the position stated by the Ninth Circuit in *Oregon v. Bowen*, and to reject the Secretary's interpretation of § 1395oo as inconsistent with the plain meaning of the statute, congressional intent, and the presumption of judicial review. In the alternative, the Court should find jurisdiciton in federal district court to review a denial of the request for reopening under federal question jurisdiction, the Court's mandamus powers, or the Administrative Procedure Act.

Respectfully submitted,

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